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Addressing

HIV/AIDS

in East Asia and the Pacific

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The World Bank
East Asia and the Pacific Region

**ADDRESSING HIV/AIDS IN EAST ASIA
AND THE PACIFIC**

**East Asia and Pacific
Human Development Sector Unit
World Bank**

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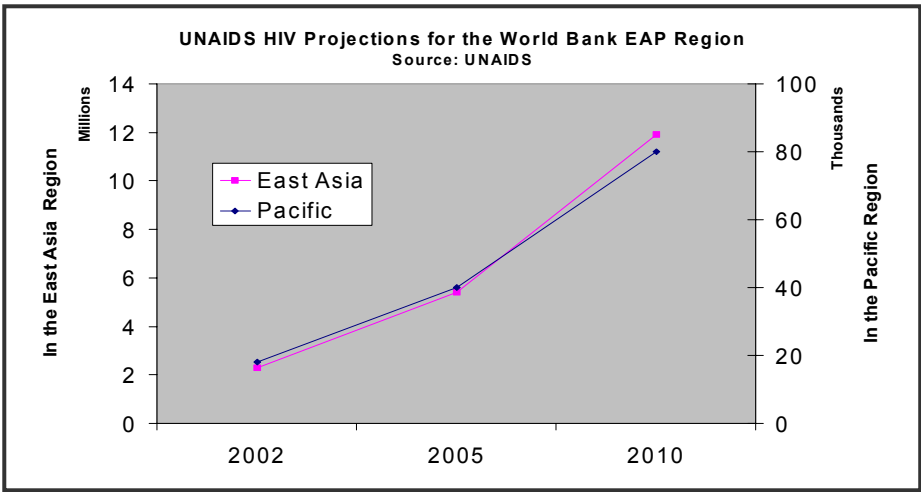
Asia, with almost half the world's population, could determine the future of the global HIV/AIDS pandemic. If prevalence rates in China, Indonesia, and India increase to numbers similar to those seen in Thailand and Cambodia, the rate of HIV/AIDS would double globally. Such growth would be devastating for individuals—and for the region's health systems, economies, and social fabric. HIV/AIDS is thus a multisectoral development challenge and, consequently, a corporate priority for the World Bank.

This booklet outlines a strategic direction for the World Bank in its response to HIV/AIDS in the East Asian and Pacific region.¹ It describes the risk of a large-scale HIV/AIDS epidemic in the region. It also spells out options for responding to the HIV/AIDS epidemic – and what government, civil society, and other partners are doing. And it identifies how the Bank can assist at the country and regional levels.

Characteristics of HIV/AIDS in the East Asia and Pacific region

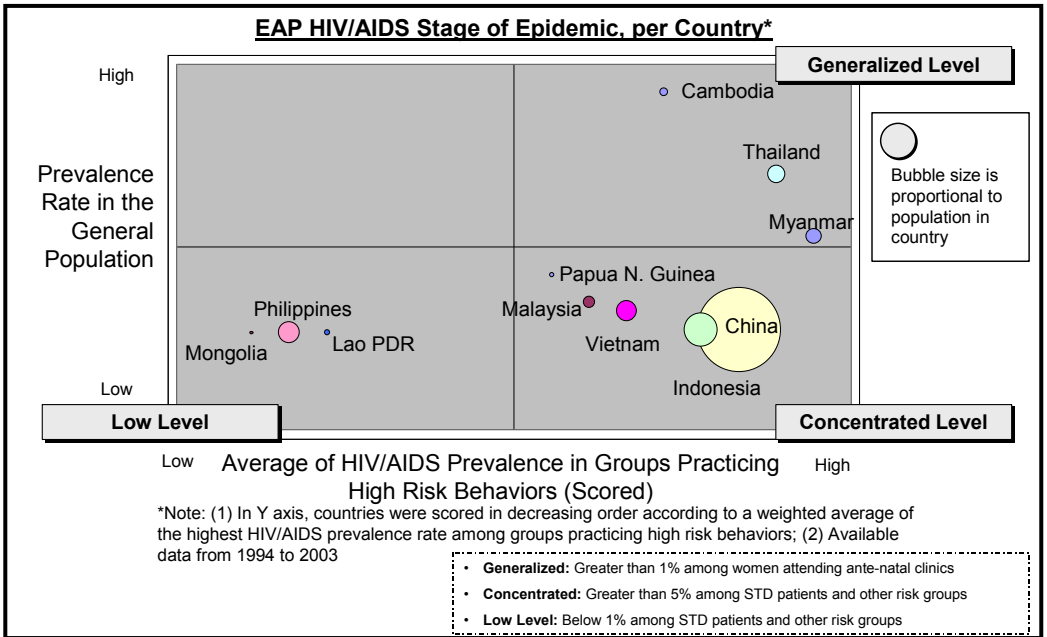
In trying to predict the course of the epidemic in East Asia, preconceived notions of the trajectory of HIV/AIDS in other parts of the world may not be applicable. East Asia is likely to experience concentrated epidemics among groups that practice high-risk behaviors, with spread to their partners and their children.

UNAIDS predicts a staggering 11 million new cases of HIV/AIDS in the region by 2010. But this projection is based on limited data. And before accurate projections can be developed, more needs to be known about how many people are affected by the disease and how many people practice behaviors that put them at risk.



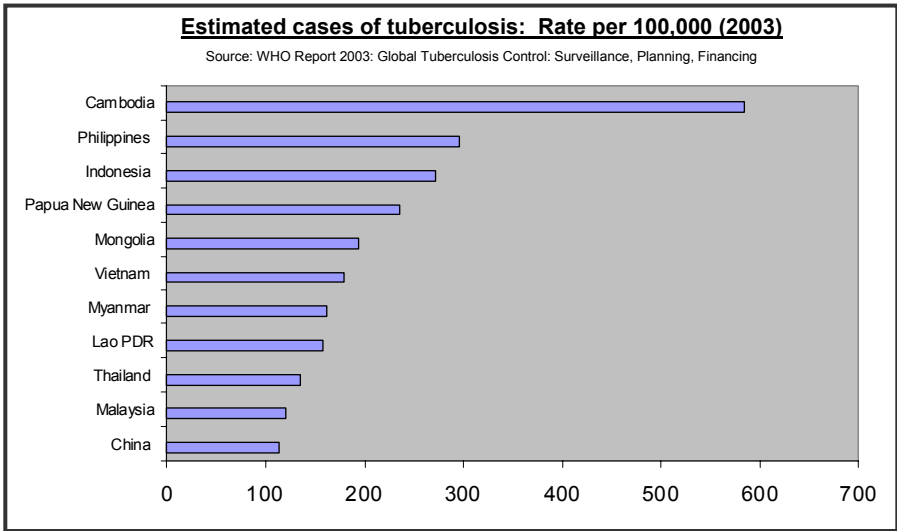
In the East Asia and Pacific region, the epidemic generally begins at a low level among commercial sex workers regularly having unprotected sex with clients, injecting drug users sharing needles and syringes, or men having unprotected sex with men. As HIV spreads among them, it becomes more heavily concentrated in these populations. And it could then spread among these (often overlapping) populations—and possibly to the general population.² When HIV has come close to saturation in populations with high-risk behaviors and HIV rates grow to greater than 1 percent among the general population, the epidemic is considered to be generalized. The trajectory of growth depends on the size of the at-risk populations and their overlaps.

Although the data are limited, predictions about the epidemic in EAP range from rates similar to those in Sub-Saharan Africa, to estimates of less than one percent prevalence in the general population. But there is no doubt of the strong potential for the epidemic to grow in many countries, such as China, Indonesia, and Papua New Guinea. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates suggest that epidemics can be sizable without HIV/AIDS becoming a generalized epidemic in the entire population. It has been estimated that significant epidemics beyond 3–5 percent prevalence could occur in the adult population simply because of the size of the groups that practice high-risk behavior.³ And because many of these groups overlap, the epidemic can become self-sustaining even without generalizing to low-risk populations.



Implications in the health sector and beyond

Because AIDS makes people more susceptible to opportunistic infections, it will trigger concomitant growth in tuberculosis (TB) in the region, which already accounts for almost a third of the global TB burden.⁴ Given these extremely high rates of TB, increases in HIV would lead to a dangerous dual epidemic. Globally, tuberculosis has already become the leading cause of death among people with HIV, accounting for about a third of the AIDS deaths worldwide.⁵



Increases in HIV/AIDS and tuberculosis will boost demand for health services and put added stress on already overburdened public health systems, particularly in providing services to the poor. The effects will extend beyond the health sector, as families would lose wage-earners and spend their limited resources on medical care. HIV could also disrupt the social fabric by breaking up families, creating orphans, and forcing more households into poverty. In general, HIV/AIDS could lead to a significant reduction in human capital, by taking the lives of youths, and to slower economic growth. HIV/AIDS is thus a threat to development and to reaching the Millennium Development Goals.

Lessons from the region

In a region as diverse as EAP, there are many lessons. Some highlights of the fight against HIV/AIDS in various contexts include experiences from Thailand, the Philippines, Indonesia, and Papua New Guinea.

In the face of a major epidemic, Thailand led the way in prevention programs, mobilizing civil society and building political commitment. By 1992, 31 percent of commercial sex workers were HIV-positive, and there were signs of HIV spreading to the heterosexual population. The national response was strong, swift, and comprehensive, thanks to strong political commitment from the King and Prime Minister. This multi-sectoral response was complemented by a sophisticated system of surveillance, including serological surveillance of the general population, sentinel surveillance of groups practicing high-risk behaviors, and behavioral

surveillance monitoring risky behavior. This information was backed by strong leadership to support HIV-prevention programs among commercial sex workers and their clients. The result: a profound decline in high-risk behavior, reducing new cases of HIV and eventually decreasing the level of HIV in the population.

But HIV/AIDS transmission remains high among injecting drug users in Thailand. And prevention programs have been cut back, particularly since the Asian economic crisis in 1998. There is some concern that the behavior changes early in the epidemic could diminish as the perceived risks decline and prevention programs reach fewer people.

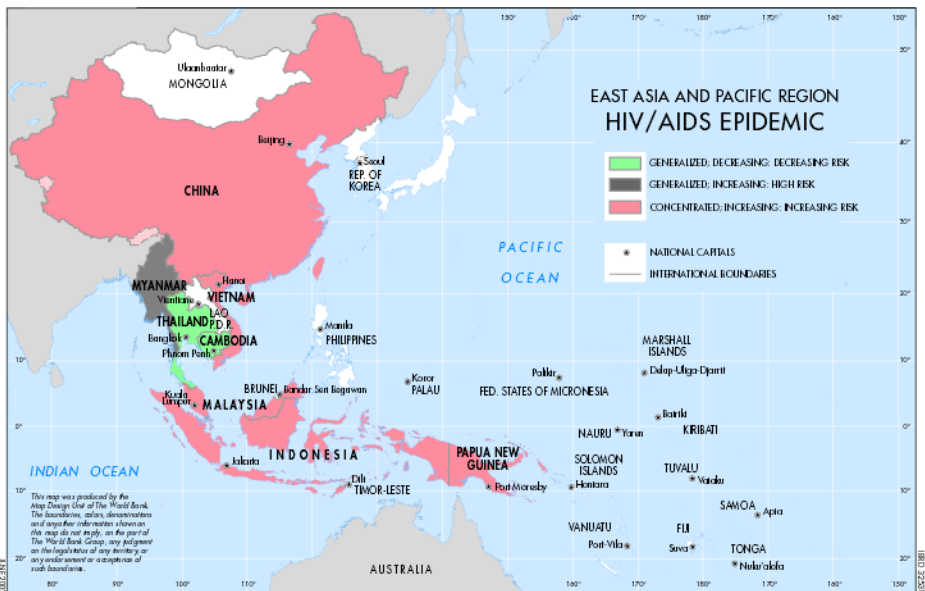
The Philippines provides another success story for the region but in a completely different context. The epidemic in the Philippines has been stemmed by a set of contextual factors (differing commercial sexual practices, low rates of injecting drug use, high rates of circumcision, and fewer ulcerative sexually transmitted infections). And the country's measured response to the epidemic—national law reform to reduce the likelihood of discrimination, widely available voluntary counseling and testing services, and a fair sentinel surveillance system—have helped to keep the prevalence low and stable.

Indonesia points to the need to maintain political commitment to prevention in the low-level stage of the epidemic. In 1996 the government recognized the importance of an early intervention to prevent an epidemic and mobilized initiatives and funding. Several programs were designed to respond to the projected epidemic. However, many of the efforts were not sustained or scaled up. Several factors played into this, including the severe economic crisis and limited capacity. Responsibility for HIV/AIDS was split into several parts of the Ministry of Health, and there was limited coordination. Capacity among nongovernmental organizations for preventive activities and support from some sectors of civil society, particularly religious groups, was also limited.

Even so, HIV prevalence remained low, and the predicted epidemic did not materialize. But the trajectory of HIV/AIDS in Indonesia has since changed, with HIV prevalence rates of more than 60 percent among injecting drug users in some areas of the country. Recently, government commitment appears to be increasing, and a new HIV/AIDS strategy embraces HIV prevention for groups that practice high-risk behaviors.

Limited capacity and cultural mores different from other countries in the region place Papua New Guinea at risk for an epidemic similar to those in

Sub Saharan Africa. Despite numerous alerts raised in the early 1990s to the emerging epidemic, few persons in positions of leadership acknowledged HIV/AIDS as an issue of concern. After recognition of the problem, however, early efforts became difficult to sustain. The National AIDS Committee functioned only sporadically from 1988 to 1994, and efforts in the early 1990s to establish a sentinel surveillance system faltered. More recent efforts have revitalized some programming, however, to date, limited capacity in the health system, poor implementation of HIV programs in general, and a lack of human resources have hampered efforts. In addition, the breakdown of traditional methods of social control in PNG, combined with the cash economy, urbanization and greater mobility, has resulted in significant changes in sexual behavior. These factors place Papua New Guinea at risk for developing a large, heterosexual HIV/AIDS epidemic.



Other countries will face similar challenges. It would be a difficult task to define the depth and breadth of lessons learned in all countries throughout the region. The examples given, however, show the broad range of experiences, highlighting some important lessons. The concentrated epidemics of China, Vietnam, and Malaysia also exhibit a mixed fare of projects, responses and inputs. But, unfortunately there is strong potential for HIV growth in all of these countries, especially China. China's emerging epidemic is considered to be the next big challenge on the

horizon. HIV and AIDS cases are increasing, and there is spread from high-risk populations to the general population.⁶ China has made progress in moving towards a system of voluntary blood donations and creating the infrastructure necessary to ensure the safety of the blood supply. In addition, the Chinese central government recently reaffirmed its commitment to achieving the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) goals. They plan to improve laws and regulations, to launch public awareness campaigns, to protect the rights of people living with HIV/AIDS, to increase international cooperation on HIV/AIDS, and to provide anti-retrovirals. Many other countries have created similar national AIDS strategies. For example, Vietnam recently completed their national strategy. But action is what is now needed. The way these and other strategies and lessons are adopted and adapted within the East Asian region will determine the future of the epidemic and the social and economic landscape of Asian society.

Partners in the response: Governments, donors, and beyond

Strong political commitment is a key element in confronting the epidemic. But resources are also important. And although there has been a high level of commitment from many governments, funding has been low. The major sources of funding for HIV/AIDS prevention and surveillance in the region have come from development agencies working alongside governments. The main development partners have been the World Bank, the Asian Development Bank, the UN agencies (especially UNAIDS), the World Health Organization, the large bilateral development agencies, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Nongovernmental organizations (NGOs) are also offering key services and information.

Although cumulative lending in the region for HIV/AIDS stands at over \$100 million, making the World Bank an important financier of HIV/AIDS projects in the region, the structure of those in the fight against HIV/AIDS has been changing rapidly and will have an impact on World Bank funding. The Global Fund channels a large amount of resources to countries that often lack full capacity to implement or support programs. But it is largely a funding agency and is not designed to assist with the implementation of programs. That places new demands on governments and donors. Implementation and technical assistance will have to be provided by other agencies, e.g., bilaterals, the Bank, other donors.

This changing landscape makes it hard to predict the exact role the World Bank will play in the region, especially in relation to demand for World

Bank lending/grants for HIV/AIDS. However, even in an era of increased grant funding through the Global Fund and other bilaterals, the World Bank may play an important role in resource mobilization for HIV/AIDS. Demand for analytic and advisory services and capacity building efforts is also likely to increase. And we will continue our role as a co-convenor of multiple sectors, our long term presence in countries and our multisectoral programs.

Five key challenges

The East Asia and Pacific region could avert a large HIV/AIDS epidemic if countries introduce effective HIV programs that address five key challenges:

- *Political commitment and multisectoral support.* Given the sensitivity of the disease, political commitment is key to effective HIV/AIDS programs. Preventing HIV among socially marginalized groups requires a multisectoral response, particularly an enabling legal environment with the support of law enforcement.
- *Public health surveillance, monitoring, and evaluation.* Knowledge of the exact numbers of those with HIV and those practicing high-risk behaviors is extremely limited. More information is essential to estimate the potential growth of the epidemic and to allocate resources and efforts accordingly.
- *Prevention.* Prevention has been shown to be a cost-effective method of abating the epidemic. There is a wide scope for improving HIV prevention, particularly among groups that practice high-risk behaviors (commercial sex workers, injecting drug users, men who have sex with men, and migrant workers).
- *Care, support and treatment.* Demand is growing throughout the region for antiretroviral therapy. Treatment must also include care and support—including psychosocial support, voluntary counseling and testing, and care for the dying.
- *Health services delivery.* Prevention along with care, support, and treatment, have to be delivered by public health and social care systems, alongside the private sector, including NGOs. There is a definite need to strengthen and build capacity to respond to the emerging needs of the epidemic.

Strategic responses

The World Bank strategy will respond to these challenges by developing country-specific strategies based on the needs of the country and the stage of the epidemic in the country. These HIV country strategy notes will be

the basis for World Bank engagement. They will also be designed in concert with national strategic HIV plans created by governments and the World Bank Country Assistance Strategies. These HIV strategy notes will provide specific work plans that incorporate some mix of the following tools: analytic and advisory work, lending, and regional activities. And they will be designed to be flexible and innovative, focusing on the five key challenges:

Political commitment and multisectoral support

An important part of making progress in any HIV/AIDS program is using communications to build the political understanding and commitment across a broad spectrum of sectors (i.e., health, education, transport, etc.) and to increase public awareness and support for HIV/AIDS prevention programs within countries. Analytic work and lending (granting) operations will help identify key stakeholders, their relative importance, and their institutional setting. It will also assist in identifying the key sectors and help us do a better job integrating multisectoral approaches in country work.

Public health surveillance and monitoring and evaluation

Public health surveillance. Good estimates of the number of injecting drug users and commercial sex workers and the percentage of the population visiting them do not exist in most countries. To estimate the growth of the epidemic, one needs to know the size of populations at risk and the overlaps among groups practicing high-risk behavior. This information is rarely known because it is governed by complex social taboos, with the behavior sometimes illegal and the population hidden. That makes it necessary to use several methods, including routine information systems from many sources, surveys, and qualitative research. More funding is required for regular behavioral surveillance and social science research on sexual and drug using behaviors and for increasing the capacity to conduct this research in local universities and government agencies.

Monitoring and evaluation. A key objective is to assist countries in monitoring and evaluating the effectiveness of HIV/AIDS programs. One element of this work will be policy dialogue with governments on spending on surveillance and prevention among groups that practice high-risk behavior through the development of National Health Accounts for HIV/AIDS. We will also work with governments to develop and implement monitoring and evaluation systems including coverage of interventions for prevention and care, support and treatment. In addition, the World Bank is assisting countries in developing approaches for

monitoring and evaluation systems at the local level through the Global AIDS Monitoring and Evaluation Team.⁷

Prevention

Although prevention programs exist among groups with high risk behaviors, they are often small pilot projects. It is important to work with governments to understand the scale needed for prevention programs to have an epidemiological impact. It is also important to understand sexual and drug using networks and their overlap to gain more knowledge concerning the potential growth of the epidemic and how to intervene effectively. And there is an epidemic of sexually transmitted infections in the region which is most disturbing, which seems to be overlooked, but which needs increasing attention. There is also a risk that over time, prevention programs will receive less attention. It is essential to maintain and strengthen these interventions as a key pillar of the fight against AIDS.

Care, support and treatment

Analytic work is needed to understand how to operationalize issues related to antiretroviral therapy in the context of relatively weak systems of service delivery, including the private sector. Furthermore, antiretroviral therapy needs to be embedded into a larger system of care and support, including social services and care for the dying. And voluntary counseling and testing can help arrange for early clinical management of HIV as well as supporting risk reduction and prevention efforts.

Health services delivery

We will work with governments to help them in the formulation of better policies for both the public and the private sectors to improve access to care, support and treatment. This will mean that the growing demand for treatment with antiretroviral therapy, now being met in the private sector, will need to be accounted for. In addition, strengthening the coordination between TB and HIV/AIDS programs to ensure maximum effectiveness and efficiency is important. Finally, overall strengthening of the health care system and of absorptive capacity within the broader government is key for delivery of HIV/AIDS interventions.

Analytic work, lending (granting) and regional activities

Analytic work in the region will focus on gathering and sharing knowledge in relation to the five key challenges. This will include both country-specific and regional pieces. Our lending (granting) will need to be guided by the specific country assistance strategies and needs. We will also work towards strengthening the collaboration with other sectors and mainstreaming HIV/AIDS into other lending projects, such as those for

infrastructure and education. A broad set of lending instruments and options for client countries to address the multisectoral nature of the disease and the diverse needs across the region are available. Another area where there could be added value is in the development of regional tools that can be utilized by several countries in coordination with other partners. These could include analytic work, knowledge sharing initiatives, and other similar programs. In disseminating lessons, the East Asia and Pacific region will work closely with the World Bank Institute to build institutional capacity for controlling HIV/AIDS throughout the region.

We will also work in close partnership on a regional level with other donors and agencies. With UNAIDS, key sectors in the governments, and other partners, we will work to forge strategic country and regional responses to HIV/AIDS.

Conclusion

The sheer scale of the HIV/AIDS epidemic will require ongoing, dynamic cooperation between a broad coalition of stakeholders. It is hoped that this strategy – drawn from the World Bank’s experience as well as that of the many partners with whom the Bank is working – will help inform future discussion and action.

Notes

¹ Cambodia, China, Indonesia, Lao PDR, Malaysia, Mongolia, Myanmar, Papua New Guinea, Philippines, Thailand, Timor Leste, Vietnam, and the Pacific Island Member States (Fiji, Kiribati, Marshall Islands, the Federated States of Micronesia, Palau, Samoa, Solomon Islands, Tonga, and Vanuatu)

² At the different stages, various risk behaviors will be the leading factors in driving the epidemic. In a majority of EAP countries such as in Vietnam, China, Indonesia, Myanmar, at the very beginning, IDU was the driving force for the HIV epidemic, as it was responsible for the sharp increase of HIV in these countries. At least in the foreseeable future, the dual HIV epidemic among CSWs and IDUs will be a key characteristic of HIV in EAP Region.

³ A sense of the magnitude of the HIV/AIDS epidemic can be drawn from a rough classification based on prevalence rates, which are the total number of people with the disease as a share of the population at risk. It should be noted, however, that there are numerous discrepancies in HIV data. To ensure a minimal level of standardization, numbers were first taken from 2002 UNAIDS data when possible. Other sources of information may lead to a slightly different classification (e.g., Papua New Guinea may be classified as a generalized epidemic based on recent national surveillance). The categories for EAP are:

Generalized: Cambodia, Thailand, and Myanmar. HIV is close to saturation in populations whose members practice high-risk behaviors, and HIV rates are greater than 1 percent among the general population, as measured by antenatal clinic attendees.

Concentrated: China, Indonesia, Malaysia, Papua New Guinea, and Vietnam. HIV prevalence surpasses 5 percent in one or more subpopulations presumed to practice high-risk behavior, as measured by sentinel surveillance of groups such as commercial sex workers and injecting drug users, but prevalence among the general population is less than 1 percent.

Low level: Lao PDR, Mongolia, Pacific Island Member States, Philippines, and Timor-Leste. HIV prevalence is less than 5 percent in all known subpopulations presumed to practice high-risk behavior.

⁴ WHO. 2003. *WHO Report 2003: Global Tuberculosis Control: Surveillance, Planning, Financing, World Health Organization*. Geneva.

⁵ UNAIDS (Joint United Nations Programme on HIV/AIDS). 2000. *Report on the Global HIV/AIDS Epidemic*. Geneva.

⁶ China MOH, UNAIDS. 2003. *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China*.

⁷ Following extensive work to encourage agreement on core indicators for monitoring and evaluating HIV/AIDS programs and policies, the UNAIDS family established the Global AIDS Monitoring and Evaluation Support Team (GAMET), based at the World Bank. Other key agencies such as the GFATM, bilaterals like USAID, and technical agencies such as the U.S. Centers for Disease Control and Prevention (CDC) are part of this partnership. GAMET actively works with countries and diverse donors to strengthen monitoring and evaluation capacity at the country level, based on normative guidance from UNAIDS' Monitoring and Evaluation Reference Group. GAMET focuses, with other agencies, on helping countries to build and use monitoring and evaluation systems which will enable them to both report on progress internationally, and especially important, to identify and make tactical changes in HIV/AIDS programs and policies that improve their effectiveness.